California Hospital Association
No Surprises Act
Analysis of State vs. Federal Enforcement Responsibility

Overview:
The No Surprises Act (NSA) protects patients from surprise medical bills in certain out-of-network situations. Beyond protections from surprise medical bills, the law also includes a wide range of coverage and transparency provisions that require enforcement.

The law intends for states to be the primary enforcement agent for the NSA's provisions. However, recognizing that not all states have the legal authority or resources to enforce the NSA's provisions, the law also allows for the Centers for Medicare & Medicaid Services (CMS) to enforce provisions that a state chooses not to. Therefore, a state may elect to enforce one or more of the NSA's provisions itself, it may elect to enter into a collaborative enforcement agreement with CMS for certain provisions, or it may cede enforcement responsibility to CMS for one or more provisions.

Under a collaborative enforcement agreement, the state will perform the compliance functions of policy form review, investigations, market conduct examinations, and consumer assistance, as applicable. Only if a state is unable to obtain voluntary compliance will CMS consider undertaking formal enforcement action, to the extent warranted.

CMS has issued a letter detailing the provisions the agency will solely enforce and those that the state and CMS will enforce collaboratively. Under this agreement, the federal independent dispute resolution (IDR) process will apply for purposes of determining the out-of-network rate for items and services furnished to individuals in an insured group health plan, or group or individual health insurance coverage in California by nonparticipating providers and nonparticipating emergency facilities to which California Health and Safety Code §§ 1371.30, 1371.31, and 1371.9, and §§ 10112.8, 10112.81 and 10112.82(a) of the Insurance Code do not apply. The California Department of Insurance and the Department of Managed Health Care (DMHC) will enforce the outcome of the federal IDR process for such cases in California.

Additionally, the federal patient-provider dispute resolution process will apply for purposes of determining the amount an uninsured (or self-pay) individual must pay a provider, facility, or provider of air ambulance services for an item or service for which the billed charges substantially exceed the good faith estimate of the expected charges provided prior to furnishing such item or service. CMS will enforce the outcome of the federal patient-provider dispute resolution process in California.

The table below identifies which NSA provisions CMS will enforce and which the state will collaborate with the agency to enforce.

CHA has prepared a detailed summary of the NSA. Additional resources to help CHA members implement the law's provisions are available on the NSA resource page.

Public Health Service Act (NSA) Section	Title	Description	Enforcement Responsibility
2719 (110)	Appeals Process	- Health plan enrollees must be permitted to request an external review for adverse benefit determinations by a plan, including decisions related to whether an item or service for which the adverse benefit determination was made is subject to the requirements under those sections.	Collaborative CMS/DMHC
2746 (202)	Disclosure to Enrollees of Individual Market Coverage	- Issuers of individual health insurance coverage are required to disclose to enrollees prior to plan selection the amount of any direct or indirect compensation that the plan will pay to the broker associated with that enrollment.	Collaborative CMS/DMHC
2799A-1 (102, 107, 111)	Preventing Surprise Medical Bills	- Limits out-of-pocket costs for out-of-network emergency services - Defines cost-sharing and out-of-network payment amounts - Defines services for which the NSA applies (e.g., emergency services and those provided at an in-network hospital by an out-of-network provider) - Requires plans to include certain information on insurance ID cards and provider members an advanced explanation of benefits	Collaborative CMS/DMHC
2799A-2 (105)	Ending Surprise Air Ambulance Bills	- Group health plans and health insurance issuers are generally required to apply the same surprise billing requirements that apply to out-of-network emergency services to out-of-network air ambulance services, if the plan or issuer provides coverage of air ambulance services provided by an in-network provider.	Collaborative CMS/DMHC
2799A-3 (113)	Continuity of Care	- If an enrollee is a continuing care patient, and the contractual relationship between the plan or issuer and the provider is	Collaborative CMS/DMHC

Public Health Service Act (NSA) Section	Title	Description	Enforcement Responsibility
		terminated, benefits with respect to the provider or facility are terminated because of a change in terms of participation of the provider or facility. Also, if a contract between a plan and an issuer is terminated — resulting in a loss of benefits with respect to a provider or facility — then the plan or issuer must, within a timely manner, notify the enrollee of the contract or benefit termination and their right to receive transitional care from that provider under the same terms and conditions that would have otherwise applied for the shorter of 90 days or when the enrollee is no longer a continuing care patient.	
2799A-4 (114)	Maintenance of Price Comparison Tool	- Plans and issuers must offer price comparison guidance, by phone and on their website, to allow enrollees to compare the cost-sharing for items and services furnished by any participating provider in a geographic region for the applicable plan year.	Collaborative CMS/DMHC
2799A-5 (116)	Protecting Patients and Improving the Accuracy of Provider Directory Information	- Plans are required to establish a verification process to ensure accurate provider directories, a response protocol for individuals inquiring about the network status of a provider, and a publicly accessible provider database. These do not pre-empt existing state law, and patients who relied on inaccurate provider directory information would only be subject to the in-network cost-sharing amounts. The law requires that health plans verify and update provider directory information no less than every 90 days (or within two days of receiving notice of a change), as well as establish a procedure for removal of providers who are no longer in network.	Collaborative CMS/DMHC
2799A-9 (201)	Increasing Transparency by Removing Gag Clauses	- Health plans are prohibited from entering into agreements with providers who restrict the plan or issuer from sharing provider-specific cost or quality of care information to referring providers, the	Collaborative CMS/DMHC

Public Health Service Act (NSA) Section	Title	Description	Enforcement Responsibility
	on Price and Quality Information	plan sponsor, enrollees, or prospective enrollees; electronically accessing de-identified claims and encounter information for each enrollee in compliance with federal privacy laws; or sharing such information or directing that it be shared with a business associate. - Plans offering individual health insurance coverage are prohibited from entering into agreements with providers who restrict the issuer from sharing provider-specific price or quality of care information to referring providers, the plan sponsor, enrollees, or prospective enrollees; or sharing such information for plan design, plan administration, and plan, financial, legal, and quality improvement activities with a business associate in compliance with federal privacy laws.	
2799B-1 (104)	Balance Billing in Cases of Emergency Services	- Nonparticipating providers and facilities that provide emergency services are prohibited from billing and holding patients liable for amounts greater than the in-network cost-sharing that is based on the "recognized amount."	Collaborative CMS/DMHC
2799B-2 (104)	Balance Billing in Cases of Non-Emergency Services Performed by Nonparticipating Providers at Certain Participating Facilities	- Nonparticipating providers who, in a participating facility, provide non-emergency items and services covered by the patient's plan are prohibited from billing patients for amounts greater than the in-network cost-sharing that is based on the "recognized amount," unless the provider satisfies certain notice and consent requirements. This exception does not apply to ancillary services or when there is no participating provider who can furnish the item or service at the facility.	Collaborative CMS/DMHC

Public Health Service Act (NSA) Section	Title	Description	Enforcement Responsibility
2799B-3 (104)	Provider Requirements with Respect to Disclosure on Patient Protections against Balance Billing	- Each health care provider and facility must make publicly available, post on their website, and provide consumers a one-page notice. The notice must contain information on the applicable balance billing requirements, any other applicable state law requirements regarding how much the provider or facility can charge a patient for out-of-network services, and how to contact the appropriate federal agencies if the consumer believes that the provider or facility has violated the balance billing requirements and prohibitions.	Collaborative CMS/DMHC
2799B-6 (112)	Provision of Information Upon Request and for Scheduled Appointments	- When an individual schedules an item or service at least three business days in advance, providers and facilities must — within one business day of the date of scheduling — ask about the individual's insurance coverage status and whether the individual is seeking to have a claim submitted to the individual's plan or coverage, and provide a good faith estimate of the expected charges to the plan or issuer or to the individual if they are not insured or are not seeking to have a claim submitted to their plan or coverage. If the individual schedules the item or service at least 10 business days in advance, the provider or facility must meet these requirements within three business days of the date of scheduling.	CMS
2799B-7 (112)	Patient-Provider Dispute Resolution	- The secretary is required to establish a patient-provider dispute resolution process where uninsured individuals who receive a good faith estimate from a provider, but who are billed charges substantially in excess of the estimate, can seek a determination from a dispute resolution entity for the amount of charges to be paid.	CMS
2799B-8 (113)	Continuity of Care	- In the case of services provided to a continuing care patient, providers are required to accept payment from plans and issuers and	CMS

Public Health Service Act (NSA) Section	Title	Description	Enforcement Responsibility
		— if applicable — cost-sharing from patients under their prior contract terms as payment in full, and must continue to adhere to all policies, procedures, and quality standards imposed under the prior contract.	
2799B-9 (116)	Provider Requirements to Protect Patients and Improve the Accuracy of Provider Directory Information	- Providers and facilities are required to establish business processes to ensure the timely provision of provider directory information to plans and issuers. Such provider directory information must be provided when the provider or facility enters into or terminates a network agreement and when there are material changes to the provider directory information.	CMS
2799B-5 (105)	Air Ambulance Services	- Air ambulance services providers are prohibited from billing or holding consumers liable for amounts greater than the in-network cost-sharing amount.	Collaborative CMS/DMHC

Source: https://www.cms.gov/files/document/cms-letter-ca-caa-enforcement-and-dispute-resolution.pdf